SOCIAL POLICY ISSUES: AN EXPLANATION OF THE COMPOSITION, NATURE, AND FUNCTIONS OF THE PRESENT HEALTH SECTOR OF THE UNITED STATES*

VICENTE NAVARRO, M.D., D.M.S.A., DR. P.H.

Associate Professor of Medical Care and Hospitals
School of Hygiene and Public Health
Johns Hopkins University
Baltimore, Md.

IN trying to understand the present composition, nature, and functions of the health sector in the United States, one is hampered by a great scarcity of literature, both sociological and medical, that would explain how the shape and form of the health sector—the tree—is determined by the same economic and political forces shaping the entire political and economic system of the United States—the forest. In fact, the literature on health services reveals what C. W. Mills,[1] Birnbaum,[2] and others[3, 4] have found in other areas of social research: a predominance of empiricism, leading to a dominance of experts on trees who neither analyze nor question the forest.

Health-services research, like most social research, has become more and more compartmentalized, with its practitioners becoming narrower and narrower specialists, superbly trained in their own fields, but with less and less comprehension of the total. And yet the Hegelian dictum that "the truth is the whole" continues with undiminished validity. I am not belittling empirical studies: i.e., the analysis of detail; I borrow heavily from their findings. But, as Baran and Sweezy have indicated, "just as the whole is always more than the sum of the parts, so the amassing of small truths about the various parts and aspects of society can never yield the big truths about the social order itself."[5] There is, indeed, a need for an explanation of how the parts are related to each

*Presented in a panel, Breaking the Barriers to Prevention, as part of the 1974 Annual Health Conference of the New York Academy of Medicine, *Prevention and Health Maintenance Revisited,* held at the Academy April 25 and 26, 1974.

This research was supported in part by Grants 5R01 HS 00110 and 5T01 HS 00112 from the National Center for Health Services Research and Development, Rockville, Md., and Grant 5D04 AH 00076 from the National Institutes of Health, Bethesda, Md.

other, and it is in meeting this need that our empiricists have fallen short and, for the most part, have remained silent. It is to break this deafening silence that this paper has been written. Although admittedly full of assumptions, perceptions, and values, it will try to show that the composition and distribution of health-care resources are determined by the same forces that determine the distribution of economic and political power in our society. Indeed, the former cannot be understood without an understanding of the latter.

The paper is divided into three sections. The first is an analysis of the current social classes and economic structures of the United States, both outside and within the health sector. The second analyzes the different degrees by which social class influences and controls the financing and delivery of care in health institutions. The third section analyzes the effects of class on the organs of the state. It is theorized that these social-class influences on the institutions of production, reproduction, and legitimization determine the composition, nature, and functions of the health sector.

The Class Structure of the United States, Outside and Within the Health Sector

To explain and understand the composition, functions, and nature of the health sector, one must look outside the health sector and first ask who owns and who controls the income and wealth[6] of that society. To answer this question, I have to revive a forgotten paradigm of social analysis in the United States—that of social class structure. In so doing I am going against the mainstream of our sociological research, which assumes that this category has been transcended in the United States and that most of our population is middle class. Actually, in most of the press[7] and academic institutions[8] it is assumed that the contemporary United States, and the rest of the Western democracies for that matter, are being recast in a mold of middle-class conditions and styles of life. Moreover, this situation is considered to be the result of social fluidity and mobility which is believed to falsify past characterizations of the United States as a class society. This conclusion, however, seems to confuse class consciousness with class interests. Indeed, the social reality that establishes the level of social aspiration of the American population as the consumption pattern of the middle class and the assumed concomitant absence of class consciousness do not deny the existence

of social classes. As C. W. Mills pointed out:[9]

> . . . the fact that men are not "class conscious," at all times and in all places does not mean that "there are no classes" or that "in America everybody is middle class." The economic and social facts are one thing. Psychological feelings may or may not be associated with them in rationally expected ways. Both are important, and if psychological feelings and political outlooks do not correspond to economic or occupational class, we must try to find out why, rather than throw out the economic baby with the psychological bath, and so fail to understand how either fits into the national tub.

There is no convincing evidence that class consciousness or awareness does not exist. According to a study conducted in 1964, some 56% of all Americans said that they thought of themselves as working class, some 39% considered themselves middle class, and about 1% identified themselves as upper class. Only 2% rejected the entire idea of class.[10]

An analysis of the social structure of the United States shows that social classes exist. A relatively small number of people own a markedly disproportionate share of personal wealth and their income is derived largely from this ownership. Many of these owners also control the uses to which their assets are put. But increasingly this control is vested in the managers of that wealth who, although wealthy themselves, do not personally own more than a small part of the assets which they control. Both the owners and controllers of wealth constitute the upper class or, for reasons to be defined later, the corporate class. They command, by virtue of ownership or control, or both, the most important sectors of economic life. The most complete study of the distribution of ownership of wealth ever undertaken in the United States, according to Hunt and Sherman, showed that in 1956 1.6% of the population owned at least 80% of all corporate stocks (the most important type of income-producing wealth) and virtually all state and local government bonds.[11] Although no subsequent studies have been done on individual ownership of wealth, it seems highly unlikely that this concentration of economic wealth has changed significantly between 1956 and the present time.[12] A similar concentration appears in the distribution of income. Actually, Samuelson, in an excellent and graphic analogy, states in the eighth edition of *Economics* that "if we made today an income pyramid out of a child's blocks, with each layer portraying

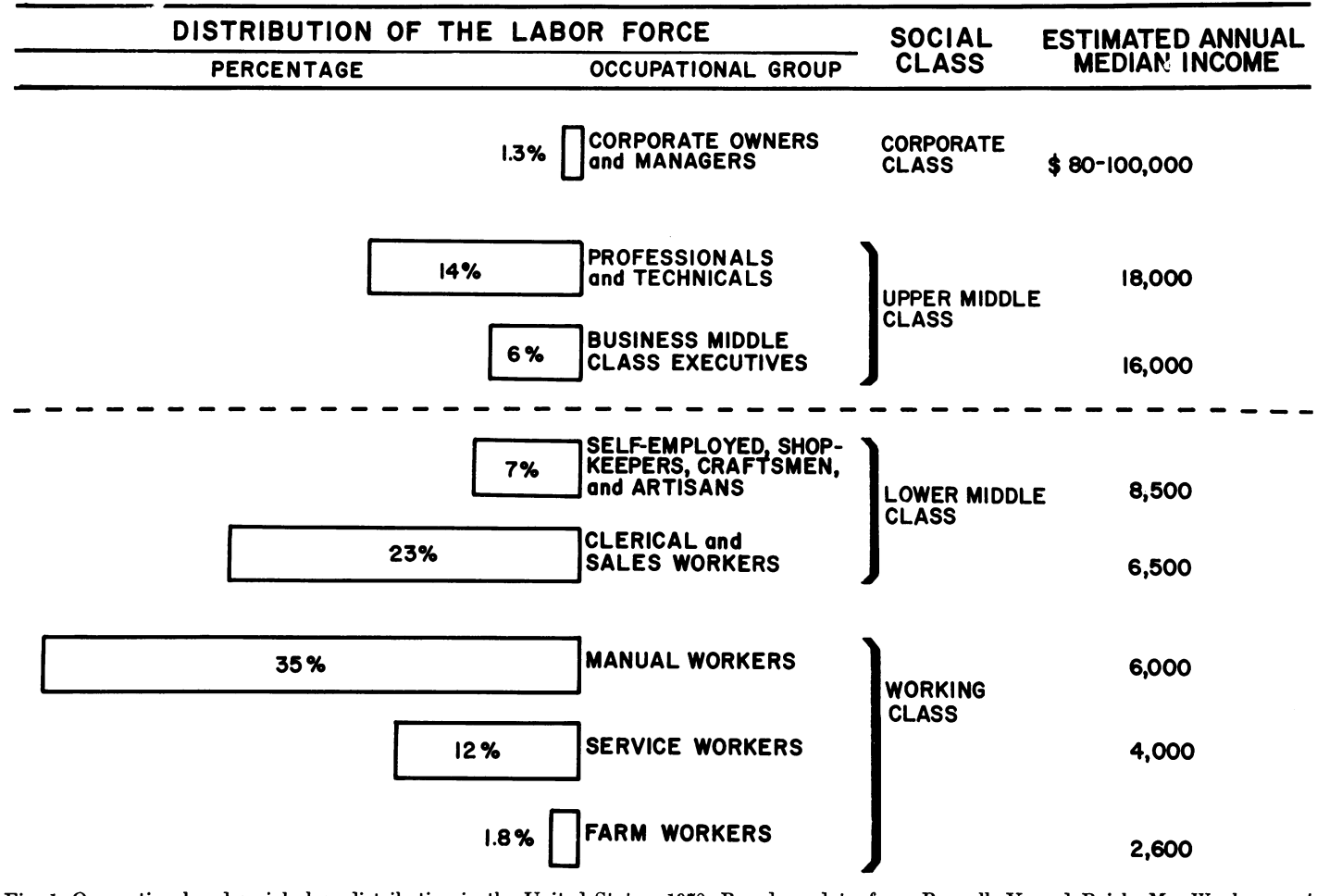


Fig. 1. Occupational and social class distribution in the United States, 1970. Based on data from Bonnell, V. and Reich, M.: *Workers and the American Economy: Data on the Labor Force.* Boston, New England Free Press, 1973; *Current Population Reports, Consumer Income: Income Growth Rates in 1939 to 1968 for Persons by Occupation and Industry Groups, for the U·ited States.* Washington, D.C., Gov. Print. Off., series P60, No. 69, 1970; Giddens, A.: *The Class Structure of the Advanced Societies.* New York, Hutchinson University Library, 1973.

$1,000 of income, the peak would be far higher than the Eiffel Tower, but almost all of us would be within a yard of the ground."[13]

At the other end of the social scale is the working class, composed primarily of industrial or blue collar workers, workers in the service sectors, and agricultural wage earners—although the latter form a steadily decreasing part of the labor force.[14] In 1970 these groups represented 35%, 12%, and 1.8% of the labor force, respectively.[15] This working class remains everywhere a distinct and specific social formation "by virtue of a combination of characteristics which affect its members in comparison with the members of other classes."[16] It is also primarily from their ranks that the unemployed, poor, and the subproletariat come.

In between these polar classes there is the middle class which consists of: 1) professionals—including doctors, lawyers, middle-rank executives, academicians, etc.—whose work is intellectual as opposed to manual, and usually requires professional training, 2) middle class businessmen associated with small and medium-sized enterprises, ranging from those employing a few workers to owners of more sizeable enterprises of every kind—these are the owners and controllers of O'Connor's competitive sector[17] or of Galbraith's market sector[18] of our economy, 3) self-employed shopkeepers, craftsmen, and artisans—a declining sector, representing less than 8% of the labor force, and 4) office and sales workers (the majority of the white-collar workers)—the group within the labor force that has increased most rapidly in the last two decades and that today represents almost one quarter of the labor force of the United States and of most Western European countries.[19] The people in this latter group differ in their career prospects, conditions of work, status, and style of life from people in the industrial working class; they view themselves as definitely not of the working class. However, in 1968 their median income, $6,000 per worker, was closer to the blue-collar workers' median income of $5,800 and to the service workers' $3,800 than to the median income of any of the other three middle class groups: e.g., the median income of the professionals was $14,000.[20]

For reasons of brevity, and accepting the simplifications that this categorization implies, I shall refer to groups 1 and 2 as the upper middle class and groups 3 and 4 as the lower middle class. Figure 1 summarizes the percentage of the labor force in each occupational group

and each social class and gives the annual median income for the occupational groups.

The distributions of wealth and income follow these class lines, with the highest possession of both at the top and the lowest at the bottom. Moreover, these distribution patterns of wealth and income have remained remarkably constant over time. In the most recent retrospective study of the distribution of income published in the 1974 annual *Economic Report of the President*[21] and widely reported in the press, it was found[22] "that the bottom 20 per cent of all families had 5.1 per cent of the nation's income in 1947 and had almost the same amount, 5.4 per cent, in 1972. At the top, there was a similar absence of significant change. The richest 20 per cent had 43.3 per cent of the income in 1947 and 41.4 per cent in 1972."

This class structure in our society is also reflected in the composition of the different elements that participate in the health sector, either as owners, controllers, or producers of services. Indeed—considering just the health sector, and analyzing the owners, controllers, and producers of services in health institutions—we find that members of the upper class and, to a lesser degree, the upper middle class (groups 1 and 2 of the middle class), predominate in the decision-making bodies of our health institutions: i.e., the boards of trustees of foundations, teaching hospitals, medical schools, and hospitals. Moreover, in analyzing the class composition of the health labor force in 1970, at the top we find the physicians, who are mainly of upper-middle-class backgrounds and who had a median annual net income of $40,000 in 1970, which places them in the top 5% of our society. The majority of persons in this group are white and male, besides being upper middle class. They represent 7.3% of the total labor force in the health sector.

Below, far below, the upper class of the health sector we find the paraprofessionals. This group is equivalent to the lower-middle-class, office-worker group (category 4): i.e., nurses, physical therapists, occupational therapists, etc., whose annual median income was approximately $6,000 in 1970. They represent 28.5% of the labor force in the health sector. This group is primarily female and is part of the lower income group. Nine percent of the group is black.

Below this group we find the "working class" per se of the health sector—the auxiliary, ancillary, and service personnel—representing 54.2% of the labor force, predominantly women (84.1%) and includ-

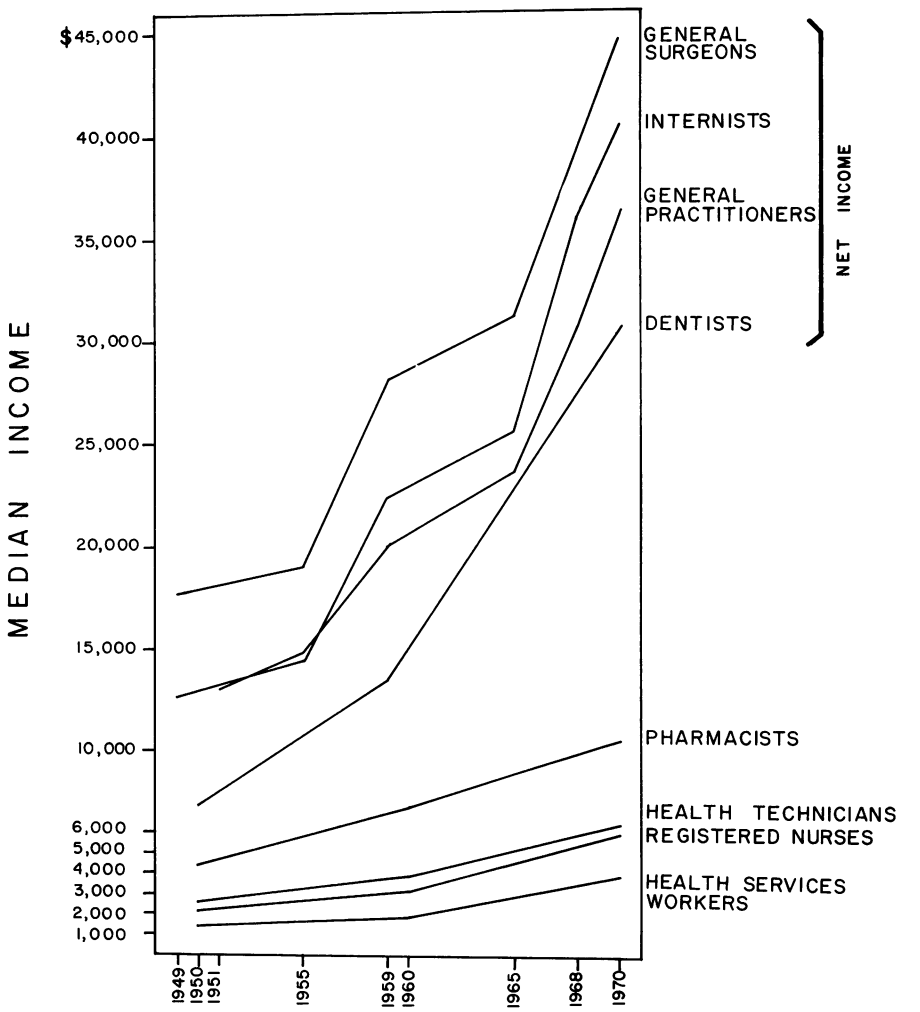


Fig. 2. The rise in income of selected personnel in the delivery of health services in the United States. Only self-employed physicians in solo practice and under 65 years of age are included. Income of physicians is based on data from continuing survey of physicians, Medical Economics Company, Oradell, N.J., 1973. Income of dentists is based on data from continuing income survey, 1951-1971, *J. Amer. Dent. Ass.* Income of other groups based on data from U.S. Bureau of the Census: *Statistical Abstract of the United States.* Washington, D.C., Govt. Print. Off., 1950, 1960, 1970.

ing an overrepresentation of blacks (30%). This group's median income was $4,000 in 1970.

If we look at income distribution in the health sector—as we did for society in general—we find a similar structure, although here again we find a great scarcity of information and a great absence of empirical data. Figure 2, however, shows the trend in the differentials of median income among the different groups of producers in the United States health sector from 1949 to 1970. We can see that there has been a very large increase in the income differentials between the top and bottom income groups of the health industry.

Determinants of Income Differentials

Much has been written about the reasons for these income differentials. According to the orthodox economic paradigm, "every agent of production receives the amount of wealth that agent creates" and "every man receives all that he creates." Thus, workers' incomes depend on their productivity: i.e., "on the amount of capital available, on the one hand, and on workers' skills and education, on the other."[23] According to this interpretation, the conditions for social mobility are: 1) increased education to improve the workers' position in the market for their skills and 2) equal opportunity for each worker in the competitive labor market. The strategy, then, is to increase educational opportunities and to break with the race and sex discrimination which prevents the market forces from functioning properly. This paradigm is shared, incidentally, by the majority of people in the black and women's liberation movements within and outside the health sector. However, the concept of property and class is missing from this analysis. Actually, one of the widely accepted theoretical works on social inequality in today's United States, Rawls' *A Theory of Justice*,[24] does not even mention the value of property as a source of social cleavage. Indeed, following the Weberian interpretation of status, Rawls and most of the exponents of what Barry[25] calls the liberal paradigm maintain that social stratification is multidimensional—depending on a variety of factors such as education, income, occupation, religion, ethnicity, and so forth.[26]

Empirical evidence, however, seems to question the main assumptions of the liberal paradigm. Regarding the social mobility that is supposed to be the result of the widening of opportunities and of the

free flow of labor-market forces and that is supposed to have caused the withering away of the social classes, Westergaard and others have recently shown that although there has been some mobility among the different social groups or strata within each social class, there has been practically no mobility between social classes.[27]

And the primary objective of education, instead of being the transmission of skills to aid upward mobility, seems to have been the perpetuation of social roles within the predefined social classes. Indeed, Bowles and Gintis,[28] among others, have indicated how the influence of education, labor markets, and industrial structures interact to produce distinctive social strata *within* each class. A similar situation prevails in the health sector, where Simpson[29] and Robson[30] in England and Kleinbach[31] in the United States have shown: 1) that the social-class background of the main groups within the health-labor force has not changed during the last 25 years and 2) that education fixes and perpetuates those social backgrounds and replicates social roles. Actually, let me point out here that Abraham Flexner himself saw the latter as a function of medical education when he wrote that a primary aim of medical education was to separate the gentlemen (the upper class) from the "quacks" (the lower class).

Education, as a perpetuation of social roles, remains the same today as in Flexner's time. Simpson, for instance, mentions that, within the five-scale grouping of classes in Britain, the offspring of social classes 1 and 2 (equivalent to our upper and upper middle classes, as defined above) predominate in medicine:[32]

> In 1961 more than a third were from class 2, rather less than a third from class 3, and only 3 per cent from classes 4 and 5 together. By 1966, social class 1 was contributing nearly 40 per cent. The proportion of children of classes 1 and 2 in universities generally, derived from the Robbins Report, is about 59 per cent. Individual medical schools vary between 69 and 73 per cent. It is hard to believe that the small number of medical students selected from families of low average income exhausts the potentially good students contained in this large part of the population.

That this situation may even follow a predefined policy is indicated in the following statement from the Royal College of Surgeons:

> . . . there has always been a nucleus in medical schools of stu-

> dents from cultured homes. . . . This nucleus has been responsible for the continued high social prestige of the profession as a whole and for the maintainance of medicine as a learned profession. Medicine would lose immeasurably if the proportion of such students in the future were to be reduced in favour of the precocious children who qualify for subsidies from the Local Authorities and State purely on examination results.[33]

A similar situation exists in the United States, where Lyden, Geiger, and Peterson reported in 1968 that only 17% of physicians were the children of craftsmen or skilled and unskilled laborers (who represented 57% of the entire labor force), while more than 31% of physicians were children of professionals (representing 4.9% of the labor force).[34] Actually, it is quite interesting and, I would add, not surprising to note that while the under-representation of women and blacks among new entrants to the medical schools has diminished slowly but steadily over the last decade, the under-representation of entrants with working-class and lower-middle-class backgrounds has remained remarkably constant during the same period. Indeed, women, who represent 51% of the population of the United States, made up 6% of all medical students in 1961 and 16% in 1973 while blacks, representing 12% of the over-all population, increased during the same period from 2% to 6% of all medical students. During these years the percentage of medical students who came from families earning the median family income or below—representing approximately one half of the population—remained at 12%. This percentage, incidentally, has remained the same since 1920.[35]

These accumulated bits of evidence would seem to indicate that there is not an automatic trend toward diminishing class differences or bringing about social-class mobility within and outside the health sector of the United States and, I postulate, in that of most Western European societies. As in the past, experience still seems to show that, as Harold Laski used to say, "the careful selection of one's own parents"[36] remains among the most important variables that influence one's power, wealth, income, and opportunities. The importance of this selection, moreover, seems to be particularly vital at the top. As C. W. Mills said, "It is very difficult to climb to the top . . . it is much easier and much safer to be born there."[37]

It would seem, then, that the liberal paradigm does not sufficiently

explain the composition of the labor force and its class and income structure. Indeed, I would postulate that a better explanation of that structure would be that the inequalities of income, wealth, and—as we shall see later—economic and political power are functionally related to the way in which the means of production and reproduction of goods, commodities, and services and the organs of legitimization in the United States are owned, controlled, influenced, and directed. According to this interpretation, property and control of and/or influence on those means of production, reproduction, and legitimization are not just marginal factors in explaining class structure and income differentials as the liberal paradigm would suggest, but rather key explanatory ones. Thus, in this alternative explanation the over-all distribution of wealth and income depends on who owns, controls, influences, and directs the means of production, reproduction, and legitimization in the different sectors of the United States economy. Over-all income differentials among social classes, then, have not so much to do with the free operation of the labor market forces, but more with the patterns of ownership and control of the main means of income-producing wealth and of the organs of legitimization, i.e., communication, education, and the agencies of the state.[38] And, according to this alternative explanation, education and other means of socialization are not the means of creating upward mobility among social classes, but of perpetuating patterns of control and ownership.

In summary, it can be postulated that social classes and income differentials come about because of the different degrees of ownership, control, and influence that different social classes have over the means of production and consumption and over the organs of legitimization, including the media, communications, education, and even the organs of the state. Moreover, it can be further postulated that, and, as I shall try to show in the following sections, these class influences determine not only the nature of the economic sectors in the United States today but also the nature of the social sectors—including that of the health services. But, before discussing this, allow me to outline briefly the different sectors of our economy and their class composition as a necessary prologue to explaining the nature, roles, and functions of the health sector.

The Monopolistic, Competitive, and State Sectors of the United States

O'Connor[39] and Galbraith,[40] among others, have recently defined three different sectors in our economy: the planned or monopolistic sector, the market or competitive sector, and the state sector.

The first, the planned or monopolistic sector, employs roughly one third of the labor force. It is capital intensive as opposed to labor intensive, national in contrast to regional or local, and highly monopolistic both in economic concentration and in economic behavior (e.g., in the use of price-fixing). Important characteristics of this sector are its requirements for economic stability and planning and a tendency toward vertical integration (e.g., the control of raw materials from the point of extraction to the process of production and distribution) as well as horizontal integration (i.e., the control of different vertical sectors of the industry and the establishment of conglomerates). If we look at the social makeup of this sector we find: 1) the corporation owners (the stockholders) and the controllers (or managers)—who, Galbraith says, together make up the "corporate community,"[41] which Miliband labels the "large business community" [42]—who, according to my own definition outlined above, would be called the corporate class; 2) the technocracy or professionals (group 1 of my categorization of the middle class); 3) the blue-collar workers, who are highly unionized, and who correspond to the industrial working class of my previous categorization; and 4) the white-collar workers, the technical and administrative workers, or lower middle class.

The second sector, the market or competitive sector, was once the largest of the three sectors but today is the smallest and continues to decline. It employs roughly less than one third of our labor force, with the largest proportion of workers being in services and distribution.[43] It is characterized by being labor intensive and local or regional in scope, with a relatively weak labor force and low unionization. Examples of workers in this sector are people working in restaurants, drug stores, commercial display, etc. The social makeup of this sector consists of: 1) the owners and controllers (executives) of small-scale, localized industries and services (group 2 of my categorization of the upper middle class), 2) a small percentage of blue-collar workers, 3) a small percentage of white-collar workers, and 4) a large sector of service workers, primarily auxiliary and ancillary personnel.

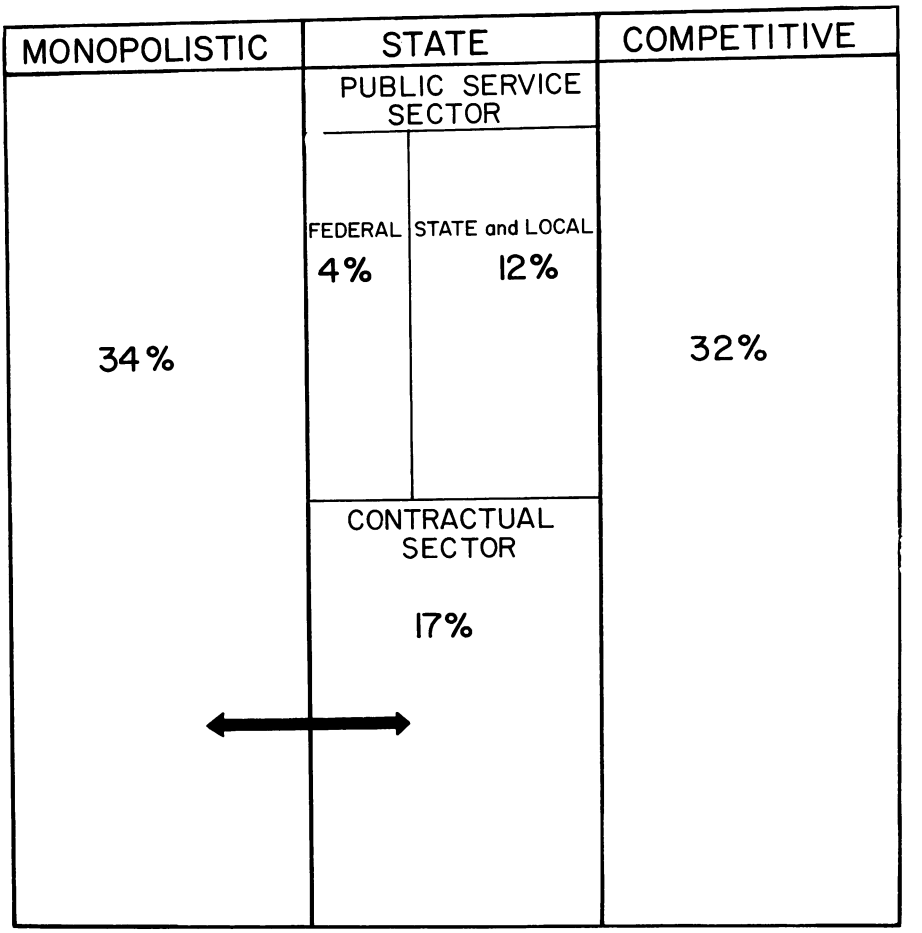


Fig. 3. Approximate percentage of the labor force in each sector of the economy in the United States. Based on data from O'Connor, J.: *The Fiscal Crisis of the State.* New York, St. Martin's Press, 1973; Bonnell, V. and Reich, M.: *Workers and the American Economy: Data on the Labor Force.* Boston, New England Free Press, 1973.

The third major sector is the state sector, which is made up of two subsectors. The first subsector produces goods and services under the direction of the state itself: e.g., public health services; the second involves production organized by industries under contract from the state. The contracts (e.g., for military equipment and supplies) are mainly with corporations belonging to the monopolistic sector. In terms of social makeup, the first subsector, employing close to 17% of the labor force, has characteristics similar to those of the market system, while

	MONOPOLISTIC	STATE		COMPETITIVE
		CONTRACTUAL	SERVICE	
CHARACTERISTICS OF PRODUCTION	• PRIMARILY MANUFACTURING		• PRIMARILY SERVICE	• PRIMARILY TRADE and SERVICE
	• ECONOMIC CONCENTRATION		• ECONOMIC DECONCENTRATION	• ECONOMIC DECONCENTRATION
	• HIGHLY MONOPOLISTIC		• MONOPOLISTIC	• COMPETITIVE
	• VERTICAL and HORIZONTAL INTEGRATION (CONGLOMERATES)		• VERTICAL and SECTORIAL	• VERTICAL and SECTORIAL
	• NATIONAL and INTERNATIONAL		• FEDERAL, STATE, LOCAL	• REGIONAL and LOCAL
CHARACTERISTICS OF LABOR FORCE	• PREDOMINANTLY MALE		• PREDOMINANTLY FEMALE	• PREDOMINANTLY FEMALE
	• NONWHITES: UNDERREPRESENTED		• NONWHITES: PROPORTIONALLY REPRESENTED	• NONWHITES: OVERREPRESENTED
	• UNIONIZED		• NONUNIONIZED	• NONUNIONIZED
	• SALARIES: RELATIVELY HIGH		• SALARIES: MEDIUM	• SALARIES: LOW

Fig. 4. Characteristics of production and labor force in each sector of the economy in the United States. Based on data from O'Connor, J.: *The Fiscal Crisis of the State.* New York, St. Martin's Press, 1973; Bonnell, V. and Reich, M.: *Workers and the American Economy: Data on the Labor Force.* Boston, New England Free Press, 1973.

DISTRIBUTION OF CORPORATE ASSETS FOR ALL CORPORATIONS IN THE UNITED STATES, 1967

Minimum assets	%	%
0	59.00	1
$ 100,000	29.00	5
500,000	10.00	10
5,000,000	1.94	31
250,000,000	0.06	53
Total	100.00	100

Based on data from U.S. Internal Revenue Service: Statistics of Income, *Corporation Income Tax Returns.* Washington, D.C., Govt. Print. Off., 1967.

the other—the contractual one—also employs 17% of the labor force and is part of the monopolistic sector. Figure 3 summarizes the percentage of the labor force in each sector and Figure 4 the main characteristics of the production and labor force in each sector.

Of these three sectors, the most important one for an explanation of the present economic system in the United States and also for a partial explanation of the situation in the health field is the monopolistic sector. Actually, the owners and controllers of that sector, the American corporate class, have a pervasive and constant dominant influence[44] over the patterns of production and consumption in the United States. Their influence affects the most important means of production and distribution in the United States, as well as the means of value generation including the media, the educational institutions, and the organs of the state.

I believe that in the health sector that same class—augmented by the upper middle classes (the professionals and the business middle class of my categorization)—maintains a dominant influence on 1) the financial and health-delivery institutions, 2) the health-teaching institutions, and 3) the organs of the state in the health sector.[45]

The Control of the Financial and Health-Delivery Institutions

The Structure of the Monopolistic Sector and its Meaning in the Health Sector

A major charcteristic of the economies of the United States and most Western nations is the concentration of economic wealth in the monopolistic sector. The accompanying table, for instance, shows the extremely high concentration of corporate assets in comparatively few firms.

At the top, in 1967 a few giant corporations (958, or 0.06%) held a majority of all assets ($1,070 billion, or 53.2%), while at the bottom, a large number of small corporations (906,458, or 59% of the total) held a very small portion of corporate assets ($31 billion, or 1.5%).[46]

This concentration of corporate economic power replicates itself in the several sectors that constitute the economy of the United States. For example, in the key sector of manufacturing in 1962 a mere 100 firms (of a total of 180,000 corporations and 240,000 unincorporated businesses) owned 58% of the net capital assets of all the hundreds of thousands of manufacturing corporations. Another way of expressing this extraordinary degree of concentration is, as Hunt and Sherman point out, that "the largest 20 manufacturing firms owned a larger share of the assets than the smallest 419,000 firms combined."[47]

Another sector within the corporate side of the economy is the financial capital sector, which includes the banks, trusts, and insurance companies. Highly concentrated itself,[48] this group exerts a dominant influence on the corporate sector, primarily through lending to the corporations. Actually, as a congressional committee report indicated recently,[49] accumulated evidence shows that corporations are not self-sufficient in terms of financial capital but are increasingly dependent on the financial institutions for their capital needs. This dependency leads to influence on corporate policies by the financial capital institutions through ownership of corporate stocks and the interlocking of directorships in their boards. As Morton Mintz of the *Washington Post* wrote in summarizing the findings of that report, "Most of the nation's largest corporations appear to be dominated or controlled by eight institutions, including six banks."[50] Through their boards, these banks have interlocking relations with insurance companies such as Aetna Life, Prudential, and others. And it may give you an idea of the formidable concentration of power in those financial institutions when I tell you that, again according to that report, the four most important banks in the country own 10% of ITT stocks, 12% of Xerox, 22% of Gulf Oil, 10% of International Paper, 12% of Polaroid, and parts of many other powerful corporations. The importance of these figures may be shown by the fact that the House Banking and Currency Subcommittee of the United States Congress has stated that ownership of 5% of the stock in a corporation is sufficient to give the owners a controlling vote in that corporation.[51]

Not surprisingly, the major financial institutions are also important in the health industry, the second largest industry in the country. According to the *National Journal*, the flow of health-insurance money through private insurance companies in 1973 was $29 billion, slightly less than half of the total insurance—health and other—sold in this country in that year.[52] About $15 billion, or more than half of this money, flowed through the commercial insurance companies. Among these companies we again find a high concentration of financial capital, with the 10 largest commercial health insurers (Aetna, Travellers, Metropolitan Life, Prudential, CNA, Equitable, Mutual of Omaha, Connecticut General, John Hancock, and Provident) controlling close to 60% of the entire commercial health-insurance industry. Most of these major health-insurance companies are also the biggest life-insurance companies, which are, with the banks, the most important controllers of financial capital in this country. Metropolitan Life and Prudential, for instance, each control $30 billion in assets, making them far larger than General Motors, Standard Oil of New Jersey, or ITT.[53] These financial entities have close links with the banking industry, and through the banks they exercise a powerful influence over the major corporations. An example of this influence is that, of 28 directors of Metropolitan Life, 23 also sit on the boards of directors of banking institutions, particularly of the Chase Manhattan Bank,[54] which owns 10% of the stock of American Airlines, 8% of those of United Airlines, 15% of the Columbia Broadcasting System (CBS), 6% of Mobil Oil, and portions of many other corporations.[55] The importance of this influence—defined by some, such as the Subcommittee on Government Operations of the United States Senate, as dominance over the over-all economy—is reflected in the current debate on different proposals for national health insurance on whether to open the doors to the commercial insurance companies or to keep them out of the coming national health-insurance scene. It speaks highly of the great political influence and power of these financial capital institutions that all the proposals—with the exception of the Kennedy-Griffith proposal, whose main constituency was the trade unions of the monopolistic sector, particularly the AFL-CIO and UAW—have left room for and even encouraged the involvement of the commercial companies in the health sector. The Nixon, and now the Ford administration's proposal, for example, would increase the flow of money through the private insurance industry (including commercial health

insurance) from $29 billion to $42 billion, with another $14 billion handled by the private carriers in their role as intermediaries in the publicly financed segment of the proposal.[56] Actually, it was the power of these commercial insurance companies that led to a change in the Kennedy-Griffith proposal—the only proposal which excluded the insurance companies—and brought about the new Kennedy-Mills proposal which accepted their role. As a recent editorial of the *New York Times* indicated, the decision of the Kennedy-Mills proposal "to retain the insurance companies' role was based on recognition of that industry's power to kill any legislation it considers unacceptable. The bill's sponsors thus had to choose between appeasing the insurance industry and obtaining no national health insurance at all."[57]

We can see, then, how the same financial and corporate forces that dominate in shaping the American economy also increasingly shape the health sector. The commercial insurance companies, however, although the largest financial powers in the premium market of the health sector, are not the only ones. They compete with the power of the providers, expressed in the insurance sector primarily through the Blues—Blue Cross and Blue Shield. The controllers of both the commercial insurance companies and the Blues, although sharing class interests, have conflicting corporate interests. Actually, it is likely that the growing predominance of financial capital, specifically of commercial insurance, in the health sector could weaken the providers' control of that sector, as the predominance of the monopolistic sector—financial and corporate—has weakened the market or competitive sector. If this should come about, we would probably see the proletarianization of the providers, with providers becoming mere employees of the finance corporations—the commercial insurance companies. In this respect the present incipient but steady trend toward unionization of the medical profession may be a symptom of the profession's proletarianization and an indication of things to come in the health sector.[58]

The Control of the Health Reproductory Institutions

In order to understand the patterns of control and influence in the health sector, we have to examine not merely the patterns of control in the financing of health services but also the patterns of control and influence in the health-delivery institutions. Indeed, financial capital, the energy that moves the system, goes through institutional channels that

are owned, controlled, or influenced by classes and groups similar, although not identical, to those which have dominant influence through financing. We can group the institutions into 1) those that have to do with the reproduction and legitimization of the patterns of control and influence: e.g., the teaching institutions and the foundations (such as the Johnson, Rockefeller, and Carnegie Foundations) and 2) those that deliver health services. Following this categorization, we could speak of reproductive versus distributive institutions.

The former are controlled by the financial and corporate communities and by the professionals (the corporate class and upper middle classes of my initial categorization). As Professor MacIver writes, "in the non-governmental [teaching] institutions, the typical board member is associated with large-scale business, a banker, manufacturer, business executive, or prominent lawyer,"[59] to which, in the health sector, we could add a prominent physician. For instance, one study showed that of the 734 trustees of 30 leading universities about half were recognized members of the professions and the other half were proprietors, managers, or bankers.[60] It is misleading to assume that the class and corporate role of such board members is a passive one or that their function is to rubber stamp what the administrators and medical faculty decide. In fact, their assumed passivity is one of delegated control. Actually, it was none other than Flexner who said in an infrequently quoted part of one of his reports, "the influence of the board of trustees . . . determines in the social and economic realms an atmosphere of timidity which is not without effect on critical appointments and promotions."[61] Indeed, in the highest decisions theirs is the first and final voice; and their first role, as Galbraith has indicated, is to ensure that "higher education, is, of course, extensively accommodated to the needs of the industrial [corporate] system" which is also referred to as the private enterprise system.[62] In 1961 Dr. N. M. Pusey, then president of Harvard, made this explicit in a remarkable speech when he said that "the university as a whole . . . is completely directed towards making the private enterprise system continue to work effectively and beneficially in a very difficult world."[63] This clearly ideological statement from the academic leader of a presumably unideological establishment is meritorious for its clarity, conciseness, and straightforwardness. And indeed, this commitment, which is typical of our academic institutions and foundations, cannot be dissociated from the fact that corporate and business leaders make up the

predominant membership of the boards of trustees of academic institutions and foundations.[64] The function and purpose of this dominant influence in the boards of trustees is to perpetuate the values that will optimize their collective benefits in terms of class and corporate interests.

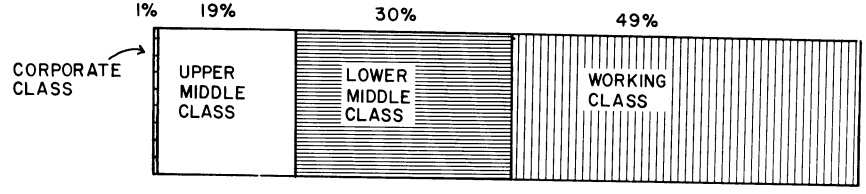
Allow me to clarify here that I do not believe that there is monopoly control in the value-generating system. However, I do think that the system of influence and control in that system is highly skewed in favor of the corporate and financial value system. And this dominant influence is felt not only in universities, foundations, and institutions of higher learning, but also in most of the value-generating systems, including the mass media and all other instruments of communication.[65] As Miliband says, all these value-generating systems do contribute to the[66]

> . . . fostering of a climate of conformity, not by the total suppression of dissent, but by the presentation of views which fall outside the consensus as curious heresies, or, even more effectively, by treating them as irrelevant eccentricities, which serious and reasonable people may dismiss as of no consequence. This is very functional (for the system).

Another indication of this dominance of corporate values can be seen in the present debate in the academic world on national health insurance. In spite of the "hot" debate as to what type and nature of national health insurance "Americans may choose," and in spite of the critical nature of comments about our health sector made by numerous members of academia and the mass media, not one of the proposals or one of the reports in the media has questioned either the sanctity of the private sector nor its pattern of control of our health institutions. Many alternatives to the present pattern—such as different types of national health services as opposed to just national health insurance—are not even thought of, or are quickly dismissed as being un-American. The sanctity of private enterprise values, however, has more to do with the pattern of control of the value-generating system by the financial and corporate

Fig. 5. Estimated composition by social class of the labor force and of the boards of trustees of reproductive and delivery institutions in the health sector of the United States. Based on data from Navarro, V.: *The Control of the Health Institutions.* Baltimore, Johns Hopkins University. In process; Pfeffer, J.: Size, composition, and functions of hospital boards of directors: A study of organization-environment linkage. *Admin. Sci. Quart. 18*:349, 1973; Hartnett, R. T.: College and University Trustees: Their Backgrounds, Roles and Educational Attitudes. In: *Crisis in American Institutions,* Currie, S., editor. Boston, Little, Brown, 1973.

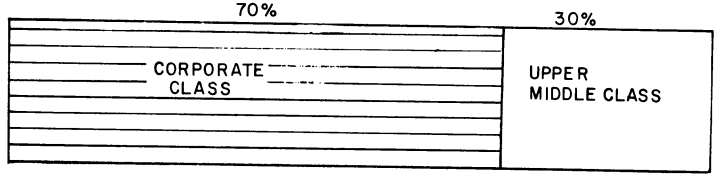
SOCIAL CLASS COMPOSITION OF U.S. LABOR FORCE



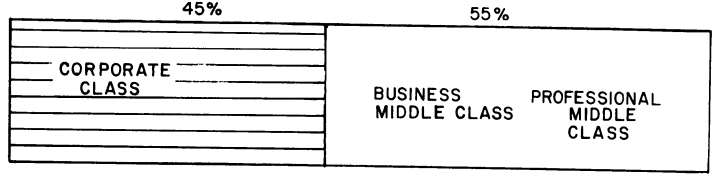
SOCIAL CLASS COMPOSITION OF BOARD MEMBERS

REPRODUCTIVE INSTITUTIONS

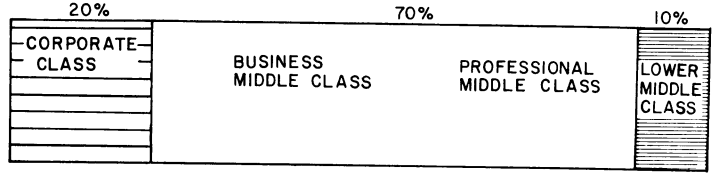
FOUNDATIONS (TOP TEN)



PRIVATE MEDICAL TEACHING INSTITUTIONS

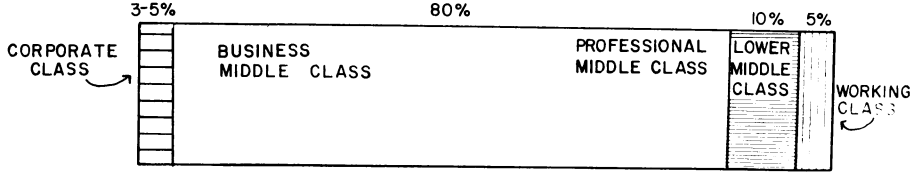


STATE MEDICAL TEACHING INSTITUTIONS



DELIVERY INSTITUTIONS

VOLUNTARY HOSPITALS



interests than with the genetic-biological structure of the American population. As Marcuse has indicated, the success of a system depends on its ability to make unthinkable the possibility of alternatives to it.[67]

The Control of the Health-Distribution Institutions

The voluntary community hospitals are the largest component of the health-distribution institutions. Analyzing the boards of trustees of these hospitals, one sees less dominance of the representatives of financial and corporate capital and more of the upper middle class—primarily of sections 1 and 2 defined above: i.e., the professionals, especially physicians, and representatives of the business middle class. Even here the other strata and classes, the working and lower middle classes which constitute the majority of the population of the United States, are not represented. Not even one token trade union leader, for instance, sits on the board of any hospital in the region of Baltimore.[68] And, of course, even less represented on hospital boards are the unorganized workers. Figure 5 presents a summary of the estimated percentage composition by class of the labor force in the United States and how the classes are represented on the boards of the reproductive and distributive health institutions.

The False Dichotomy of Providers Versus Consumers

From the previous analysis it should be clear that I disagree with most of my colleagues who perceive the present basic dialectical conflict in the health sector of the United States—both in the financing and in the delivery of health services—to be between the consumers and the providers. To me this is a simplification that obfuscates the nature of the distribution of economic and political power in the United States today, both inside and outside the health sector. Although I agree that the present delivery system seems to be controlled primarily by the providers and their different components—the patricians or those in academically based medicine, the practitioners or the American Medical Association (AMA), and the hospital organizations or the American Hospital Association (AHA)—I disagree with the proposition that an inherent control is given to them by their "unique" knowledge or that the situation cannot be changed. Actually, the power of the medical profession is delegated power. As Freidson has indicated: "A profession attains and maintains its position by virtue of the protection and patron-

age of some elite segment of society which has been persuaded that there is some special value in its work."[69] However, as Frankenberg has pointed out, this section or segment of the population is not so much an economic elite as a class: i.e., the corporate class described above.[70] Remember, incidentally, that the Flexner Report and the first scientific medical schools were funded and subsidized by the enlightened establishment of the early 1900s: i.e., the Rockefeller and Carnegie Foundations, the intellectual voices of the financial and corporate class of that period.[71]

The great influence of the providers over the health institutions—which amounts to control of the health sector—is based on power delegated from other groups and classes, primarily the corporate class and the upper middle classes, to which the providers belong. Their specific interests actually may be in conflict with the power of other groups or strata within the upper middle classes and with the greater power of the corporate class. As I have indicated elsewhere, the corporate powers of England and Sweden not only tolerated but supported nationalization of the health sector when their interests required it, formalizing a dependency of the medical profession on those corporate and state interests.[72]

To define the main dialectical conflict in the health sector as one of providers versus consumers assumes that providers have the final and most powerful control over decisions in the health sector and that consumers have a uniformity of consumer interests, transcending class and other interests. Control of the health institutions, however, is primarily control by the classes and groups described above and only secondarily control by the professions. The dialectical conflicts that exist are not, then, between the providers and the consumers, but between the corporate class and the providers over the financing of the health sector and between the majority of the population who belong to the working and lower middle classes and the controllers of the health delivery system—the corporate class, the upper middle classes, and the professionals.

The Corporate System and the State

Having described, however briefly, the patterns of influence in both the financial and the delivery systems of the health sector, I shall address myself to the final question of our analysis: who has dominant influence over the state?[73] Let me add immediately that this is far from a simple question.

Before I attempt to answer it, let me describe some unsatisfying answers. The first is that government is run by business. As one of the proponents of this theory says, "Government and Congress is run by big business."[74] And actually, this idea is similar to Marx's statement in the *Communist Manifesto* that the "state is the executive committee of the bourgeoisie."[75] It is quite interesting, incidentally, that this view seems to have been held even by past presidents of the United States. Indeed, none other than President Woodrow Wilson said that "the masters of the government of the United States are the combined capitalists and manufacturers of the United States."[76] However, I find such statements to be too much of a simplification. However, I find equally simplistic the idea, quite prevalent among scholars, that the organs of the state are above business or that business is even antigovernment. I believe this explanation to be unhistorical and unempirical. Actually, in the executive branch of government[77]

> . . . businessmen were in fact the largest single occupational group in cabinets from 1889 to 1949; of the total number of cabinet members between these dates, more than 60 per cent were businessmen of one sort or another. Nor certainly was the business membership of American cabinets less marked in the Eisenhower years from 1953 to 1961. As for members of British cabinets between 1886 and 1950, close to one-third were businessmen, including three prime ministers—Bonar Law, Baldwin and Chamberlain. Nor again have businessmen been at all badly represented in the Conservative cabinets which held office between 1951 and 1964.

With respect to the legislative branch, in 1970, as Hunt and Sherman point out:[78]

> A total of 102 congressmen held stock or well-paying executive positions in banks or other financial institutions; 81 received regular income from law firms that generally represented big businesses. Sixty-three got their income from stock in the top defense contractors; 45, in the giant (federally regulated) oil and gas industries; 22, in radio and television companies; 11, in commercial airlines; and 9, in railroads. Ninety-eight congressmen were involved in numerous capital-gains transactions; each of them netted a profit of over $5,000 (and some as high as $35,000).

It is difficult to conclude from these figures that businessmen are anti-

government although it should be pointed out that these businessmen in the corridors of power may not necessarily think of themselves as representatives of businesses holding state power. But it is highly unlikely, as Miliband says, that their vision of national interest goes against the interests of the business community. Values and beliefs do not change when the call of government takes place. The appointment of businessmen to positions of power has also been the practice in the federal health establishment. For instance, of the last 12 secretaries of Health, Education, and Welfare, nine have had business backgrounds.

On the other hand, labor leaders have been a very small minority indeed in the key positions of the executive and legislature. Let me add, though, that this situation is not unique to the United States. In Sweden —often painted as a socialist heaven by some and as a hell by others— the number of workers' sons and daughters among the top Swedish politico-bureaucratic echelons was less than 9% in 1961.[79]

This heavy involvement of businessmen in government, then, makes one question the widely-held belief that businessmen are against government. However, this heavy involvement in and influence on the state should not lead to the opposite conclusion that businessmen are the government—or at least not in the way that the land-owning aristocracy was the government in the 18th century. Other groups who represent different interests share the power of government with big business. In the executive branch of the federal health establishment, for example, other powerful groups include the professionals of academic medicine— the patricians—and, to a lesser degree, the practitioners. These two groups—while they are not the top decision makers (who are usually businessmen)—do control the next-to-top echelons of policy in the executive of the federal health establishment: i.e., they are the assistant secretaries of health and lesser officials. The medical practitioners who control the AMA tend to have more influence on the legislative branch of the federal government than on the executive. One of many examples showing the differing degrees of influence the AMA has had over the two branches of government was the recent decision of Congress to follow the AMA's wishes and exclude the health sector from cost controls despite strong opposition to this from the executive branch. Another example is that the AMA proposal for national health insurance is the proposal with the most sponsors in Congress. This selective attention by some members of Congress is not without rewards. The list

prepared by Common Cause of federal legislators who received AMA contributions during the last national election of 1972 reads like a *Who's Who* of the health sector of Congress.[80]

There is indeed a diversity of interests in the health sector. Yet within this diversity which determines the plurality of sources of power in the federal establishment there is uniformity that unites these groups and sets them apart from other groups: i.e., their social origin, education, and class situation. As Professor Matthews notes:[81]

> Those American political decision-makers for whom this information is available are, with very few exceptions, sons of professional men, proprietors and officials, and farmers. A very small minority were sons of wage-earners, low salaried workers, farm labourers or tenants . . . the narrow base from which political decision-makers appear to be recruited is clear.

In fact, the large majority of the governing classes belong, by social origin and by previous occupation, to the corporate and upper middle classes as defined above.

I am not implying, let me underline again, that the corporate class and the upper middle class which predominate in and dominate the corridors of power behave uniformly on the political scene. Indeed, they represent a variety of interests that determines what is usually referred to as the political pluralism of our society. This plurality is reflected in the different programs put forward by the main political parties. For example, it is far from my intention to imply that all proposals for national health insurance are the same or that they represent the same groups. Differences do exist. Yet the nature of this political pluralism means that the benefits of the system are consistently skewed in favor of those classes mentioned above. As an American observer has indicated: "The flaw in the pluralistic heaven is that the heavenly chorus sings with a very special accent . . . the system is askew, loaded, and unbalanced in favor of a fraction of a minority."[82] Moreover, the political debate that reflects that pluralism takes place with a common understanding and acceptance of certain basic premises and assumptions which consistently benefit some classes more than others.

Let me add that this situation is more a result of the inner logic of the system than of personalities; it is a syndrome of the distribution of economic and political power within our system. It is because of this inner logic that when there is governmental intervention the possible

benefits from that intervention are not randomly distributed but are largely predictable. The answer to the question of *cui bono?* (to whom the goods?) is predictably easy. Let me cite as an example the fiscal policies in general and taxation in particular. Titmuss[83] in Britain and Kolko[84] in this country have shown that the two countries' systems of taxation have not weakened but accentuated the inequalities of income in each country. A similar example in the health sector is the system of funding included in most of the national-health-insurance proposals: most share the common denominator of being regressive.[85]

With this introduction, let me describe the roles of state intervention as they relate to the health sector. I postulate that these roles are the legitimization and defense of the private-enterprise system and the strengthening of that system. These categories are somewhat artificial and thus their separation is one of convenience more than of necessity.

The Legitimization and Defense of the System

According to Weber, the first role of any state is to assure the survival of the economic system. Thus, the main role of the state is the legitimization of the economic and political relation by means of the different mechanisms at the state's disposal. These mechanisms range from the exclusive use of force: i.e., the armed forces and police, to the creation of social services, including the development of health services, with many mechanisms between. Bismarck, the midwife of the welfare state, first used the social-insurance mechanism as a tool for coopting threatening forces to the capitalist system of that time.[86] Social-security legislation was passed in England and other countries for similar reasons. Let me quote Henry Sigerist, the great medical historian:[87]

> Social-security legislation came in waves and followed a certain pattern. Increased industrialization created the need; strong political parties representing the interests of the workers seemed a potential threat to the existing order, or at least to the traditional system of production, and an acute scare such as that created by the French Commune stirred Conservatives into action and social-security legislation was enacted. In England at the beginning of our century the second industrial revolution was very strongly felt. The Labour Party entered parliament and from a two-party country England developed into a three-party country. The Russian revolution of 1905 was suppressed

> to be sure, but seemed a dress rehearsal for other revolutions to follow. Social legislation was enacted not by the Socialists but by Lloyd George and Churchill. A third wave followed World War I when again the industries of every warfaring country were greatly expanded, when, as a result of the war, the Socialist parties grew stronger everywhere, and the Russian revolution of 1917 created a red scare from which many countries are still suffering. Again social-security legislation was enacted in a number of countries.

Nor are we strangers to this mechanism in the United States. Piven and Cloward have shown, for example, how welfare rolls are and always have been increased to reduce unrest among the poor. It was the function of welfare programs to integrate those sectors of the population who were increasingly alienated from the political system and to give these people the feeling of being a part of the system.[88] As Moynihan has indicated for the antipoverty programs of the 1960s: "they were intended to do no more than ensure that persons excluded from the political process in the South and elsewhere could nevertheless *participate* in the benefits of the community action programs. . . ."[89]

In that respect, the lateness of the United States to come to the stage of the welfare state may be due to the lack of pressure, primarily on the corporate class, from any force that could obtain a concession from that class and achieve what the European left has achieved. The potential for threat does exist, however, and the perception of that potential is explicitly manifested in a continuous call for "law and order" and in expressed concern for the disintegration of the system. Indeed, the percentage of the American population who have expressed alienation from and disillusionment with their present system of government has reached a record high in the history of the United States. A Harris survey of public attitudes prepared for a United States Congressional committee concludes that[90]

> the most striking verdict rendered [in the survey] by the American people—and disputed by their leaders—is a negative one. A majority of Americans display a degree of alienation and discontent [with government]. . . . [Those] citizens who thought something was "deeply wrong" with their country had become a national majority.
>
> . . . And for the first time in the ten years of opinion sampling

> by the Harris Survey, the growing trend of public opinion toward disenchantment with government swept more than half of all Americans with it.

A possible response by government to that popular alienation could be the establishment of measures such as income maintenance or national health insurance aimed at integrating that alienated population into the political system. As the press has indicated, the increased attention of the present administration to the national-health-insurance issue on the political scene and the broadening of benefits could easily be related to concern with the alienation of the population—from Presidents Nixon and Ford personally and from the political system in general.[91]

The Strengthening of the Private Enterprise System

In creating a welfare state, however, the inner logic of the system—which is a product of the pattern of economic and political power as previously explained—determines that the distribution of benefits brought about through such state intervention is likely to benefit some groups more than others. Because I believe that the system functions this way, I am skeptical—as are others—that national health insurance will solve what is usually referred to as the health crisis in this country. As Bodenheimer rightly points out, it is far from clear whose crisis national health insurance is supposed to solve—that of the financial interests of the insurance industry and of the providers themselves or that of the needs of the majority of the population for available and accessible health care. Not surprisingly, after a comprehensive analysis of the flow of funds in the health sector, Bodenheimer postulates that "just as federal defense appropriations keep the military-industrial complex well subsidized, so will national health insurance supply the medical-industrial complex."[92]

Again, state intervention is not uniform since it depends on the interests of the dominant group in the area in dispute. Each of the different power groups in the health sector has put forward its own proposal aimed at optimizing its own interests. Thus, each proposal has a rationale and ideology behind it which respond to the specific economic interests of its proponents. And again reflecting the power of the insurance industry, all proposals except one have allowed or even encouraged the involvement of insurance in the health sector through state subsidization of the private-insurance industry. As Dr. Rashi Fein

has indicated—in commenting on the Nixon proposal, for example—it was part of that proposal's strategy to strengthen the private market in economic affairs of the health sector.[93] The passing of this proposal or one of the majority of others would strengthen the contractual segment of the state sector which I discussed in a previous section. Indeed, as you may recall, following the categories outlined by O'Connor and Galbraith, I divided the state sector into two subsectors: the contractual, in which the state contracts and subsidizes the private sector, primarily the monopolistic or planned sector, such as is the case of the defense industry, and the part that is owned and operated by the public sector per se, with services that are owned and run by the state, such as the public health services.

The first subsector, or the contractual one, will be strengthened with the passing of the suggested national health insurance and would further expand what O'Connor calls the social-industrial complex. The rationale for that involvement, as *Fortune* magazine says, is that[94]

> implicit in the governmental appeals for help at all levels is an acknowledgement that large corporations are the major repository of some rather special capabilities that are now required. Business executives are increasingly identified as the most likely organizers of community-action programs, like the Urban Coalition and its local counterparts. Corporate managers often have the special close-quarters knowledge that enables them to visualize opportunities for getting at particular urban problems—e.g., the insurcompanies' plans for investments in the slums. Finally, the new "systems engineering" capabilities of many corporations has opened up some large possibilities for dealing with just about any complex social problem.

Medicare and Medicaid have already begun the expansion of the contractual subsector and the rate of this expansion has established a record for the rate of growth of financial capital in this country. Indeed, from 1970 to 1973 the profits of the private health-insurance industry increased by a record 120%.[95]

Another objective of all the national-health-insurance proposals is to socialize the costs of health insurance and thus to stop the increasing drain of funds that health costs represent for both capital and labor. In 1966, for example, contributions to health-insurance plans exceeded $8 billion, or about 40% of the total costs of fringe benefits.[96]

The other subsector of the state sector, the public sector (city hospitals, public health service hospitals, and others), will be responsible for what is considered unprofitable or less profitable by the private sector. As Roemer and Mera have concisely shown, the population of patients in our city hospitals, for instance, consists for the most part of those unwanted by the private sector.[97] Thus, in the health sector there occurs what happens in other sectors. It is the perceived function of the state to strengthen the private sector through contracts and subsidies and by assuming the unwanted responsibilities of the private sector.

Conclusion

I have tried to show how the economic and political forces that determine the class structure of the United States also determine the nature and functions of the health sector. Indeed, the composition, nature, and functions of the latter are the result of the degree of ownership, control, and influence that primarily the corporate class and the upper middle classes have on the means of production, reproduction, and legitimization of our society. This interpretation runs contrary to the most prevalent interpretation, which assumes that the shape and form of the health sector is a result of American values that prevail in all areas and spheres of American life. But this explanation assumes that values are the cause and not, as I postulate, a symptom of the distribution of economic and political power in the United States. It avoids the question of which groups and classes have a dominant influence on the value-generating system and maintain, perpetuate, and legitimize it. I believe that they are the very same groups and classes that wield a dominant influence over the systems of production, reproduction, and legitimization in other areas of the economy, including the organs of state.

Let me underline once again that I do not believe that these groups are uniform, nor that their dominant influence is equivalant to control. The distinction between dominant influence and control is a key one with a number of implications, primarily in the area of strategies for stimulating change. There is a plurality of interests among groups and classes which explains and determines the political pluralism apparent today in the United States. Competition does exist, and a strategist for change must be aware of and sensitive to the diversity of interests reflected in political debate.[98] However, the competition that supports this

pluralism is consistently and unavoidably biased in favor of the dominant groups and classes. To quote the excellent description Miliband has made of this situation: "There is competition, and defeats for powerful capitalist interests as well as victories. After all, David did overcome Goliath. But the point of the story is that David was smaller than Goliath and that the odds were heavily against him."[99]

The degree of skewness in the distribution of economic and political power, both outside and within the health sector is, as I have tried to show in this presentation, very dramatic indeed. And at a time when much time and energy is being spent in academia debating what might be the most perfect model for the health sector, it might be salutary to underline that more important than the shape of the final product is who dominates the process. Thus, a primary intent of this presentation has been to show that the questions of what services to provide and for whom will actually be determined by whoever is dominant in the process of defining those questions and of formulating those answers.

I have attempted in this paper to put the tree—our health sector—within the setting of the forest: the economic and political structure of our nation. I may have left many areas loosely sketched or not defined at all, but these are risks in daring to face the totality. I am aware also that this analysis is, according to present Parsonian standards of orthodoxy, an unorthodox one. But it may in the long term serve as one more effort to question that orthodoxy. Meanwhile, I hope that in the short run it will at least stimulate students of health services to look wider and deeper than just at their own health sector.

ACKNOWLEDGEMENTS

I want to express my great appreciation to Christopher George for editing this paper, to Janet Archer for preparing the figures and the table, and to Leotta Wallace for assisting and typing the manuscript.

NOTES AND REFERENCES

1. Mills, C. W.: *The Sociological Imagination.* New York, Grove Press, 1959.
2. Birnbaum, N.: *Toward a Critical Sociology.* New York, Oxford University Press, 1971.
3. Dreitzel, H. P.: *On the Social Basis of Politics.* New York, MacMillan, 1969.
4. Coulson, M. A. and Riddell, C.: *Approaching Sociology: A Critical Introduction.* London, Routledge and Kegan Paul, 1973.
5. Baran, P. and Sweezy, P.: *Monopoly Capital.* New York, Monthly Review Press, 1968, pp. 2-3.
6. Simply stated, income is money coming from different sources, either as wages

and salaries, dividends and profits, or as rent. Wealth is the value of people's possessions and property.

7. Kumpa, P. J.: Hail to the middle Class! *Baltimore Sun*, March 10, 1974, pp. K1 and K3.
8. The most influential of the large body of sociological literature that negates the existence of classes in the United States is Bell, D.: *End of Ideology: On the Exhaustion of Political Ideas in the Fifties.* New York, Free Press, 1960. For a critique of this literature see Parker, R.: *The Myth of the Middle Class: Notes on Affluence and Equality.* New York, Liveright, 1972.
9. Horowitz, I. L., editor: *Power, Politics and People: The Collected Essays of C. Wright Mills.* New York, Oxford University Press, 1962, p. 317. Quoted in Miliband, R.: *The State in Capitalist Society: An Analysis of the Western System of Power.* London, Weidenfeld and Nicolson, 1969, p. 20.
10. Irish, M. and Prothro, J.: *The Politics of American Democracy.* Englewood Cliffs, N. J., Prentice Hall, 1965, p. 38. Quoted in Hunt, E. K. and Sherman, H. J.: *Economics: An Introduction to Traditional and Radical Views.* New York, Harper and Row, 1972, p. 284.
11. Lampman, R. J.: *The Share of Top Wealth-Holders in National Wealth, 1922-1956.* Princeton, N. J., Princeton University Press, 1956. Quoted in Hunt, E. K. and Sherman, H. J., op. cit., p. 390.
12. Upton, L. and Lyons, N.: *Basic Facts: Distribution of Personal Income and Wealth in the United States.* Cambridge Mass., Cambridge Institute, 1972.
13. Samuels, P.: *Economics,* 8th ed. New York, McGraw-Hill, 1972, p. 110.
14. In my categorization of classes and the strata within classes I have very closely followed Chapter 2, Economics Elites and Cominant Classes, in Miliband, R., op. cit., pp. 23-48. It is recognized that this categorization is far from complete, comprehensive, or even all-inclusive. Still, with all its limitations, it is presented in this article as an entry point to our understanding of the composition of the labor force in the health sector and of the distribution of economic and political power both outside and within the health sector.
15. U. S. Bureau of the Census: *Statistical Abstract of the United States: 1970.* Washington, D.C., Govt. Print. Off., 1970, p. 225.
16. Miliband, R., op. cit., p. 16.
17. O'Connor, J.: *The Fiscal Crisis of the State.* New York, St. Martin's Press, 1973, pp. 13-15.
18. Galbraith, J. K.: *Economics and the Public Purpose.* Boston, Houghton, Mifflin, 1973, pp. 55-71.
19. Dahrendorf, R.: Recent change in the class structure of European societies. *Daedulus,* Winter 1964, p. 245, cited in Miliband, R., op. cit., p. 18.
20. *Current Population Reports, Consumer Income: Growth Rates in 1939 to 1968 for Persons by Occupation and Industry Groups for the United States.* Washington, D.C., U.S. Govt. Print. Off., Series P-60, No. 69, 1970, Table A-3, p. 82; Bonnell, V. and Reich, M.: *Workers and the American Economy: Data on the Labor Force.* Boston, New England Free Press, 1973.
21. U.S. Congress: *Economic Report of the President, 1974.* Washington, D.C., Govt. Print. Off., 1974.
22. Shanahan, E.: Income distribution found unchanged. *New York Times,* February 2, 1974, p. 10.
23. All these quotations are from Clark, J. B.: *The Distribution of Wealth.* New York, MacMillian, 1924. Quoted in Silverman, B. and Yanowitch, M.: Radical and liberal perspectives on the working class. *Social Policy 4:*43, 1974. The marginal productivity of income distribution was first enunciated by Clark in this work. The most important contemporary work in this area is P. Samuelson's *Economics,* op. cit.
24. Rawls, J.: *A Theory of Justice.* Cambridge, Mass., Harvard University Press, 1971.
25. Barry, B.: *The Liberal Theory of Justice: A Critical Examination of the Principal Doctrines in "A Theory of*

Justice" by John Rawls. Oxford, Clarendon Press, 1972.
26. Quoted in Silverman, B. and Yanowitch, M., op. cit., p. 43.
27. Westergaard, J. H.: Sociology: The Myth of Classlessness. In: *Ideology in Social Science,* Blackburn, R., editor. New York. Fontana, 1972, pp. 119-63.
28. Bowles, S. and Gintis, H.: IQ in the U. S. class structure. *Social Policy 8:* 65-96, 1973.
29. Simpson, M. A.: *Medical Education: A Critical Approach.* London, Butterworths, 1972.
30. Robson, J.: The NHS Company, Inc.? The social consequence of the professional dominance in the national health service. *Int. J. Health Serv. 3:* 413-26, 1973.
31. Kleinbach, G.: Social structure and the education of health personnel. *Int. J. Health Serv. 4:*297-317, 1974.
32. Simpson, M. A., op. cit., p. 39.
33. *Evidence of the Royal College of Surgeons to the Royal Commission on Doctors and Dentists Remuneration.* London, Her Majesty's Stat. Off., 1958. Quoted in Robson, J., op. cit., p. 415.
34. Lyden, F. J., Geiger, H. J., and Peterson, O.: *The Training of Good Physicians.* Cambridge, Mass., Harvard University Press, 1968. Cited in Simpson, M. A., op. cit., p. 35.
35. All these figures are cited in Kleinbach, G.: *Social Class and Medical Education.* Cambridge, Mass., Dept. Educ. Harvard University, 1974.
36. Quoted in Miliband, R., op. cit., p. 40.
37. Mills, C. W.: *The Power Elite.* New York, Oxford University Press, 1956, p. 39.
38. The term "state" includes those institutions—the executive, the legislature, the military and police, and the judiciary—whose interrelations shape the form of the state system. Miliband, R., loc. cit.
39. O'Connor, J., loc. cit.
40. Galbraith, J. K., loc. cit.
41. Ibid.
42. Miliband, R., loc. cit.
43. O'Connor, J., loc. cit.
44. By dominant or hegemonic influence I mean that influence which is most important in determining "an order in which a certain way of life and thought is dominant, in which one concept of reality is diffused throughout society in all its institutional and private manifestations, informing with its spirit all taste, morality, customs, religious and political principles, and social relations, particularly in their intellectual and moral connotations." Williams, G. A.: Gramsci's concept of egemonia. *J. Hist. Ideas 21:*587, 1960. Quoted in Miliband, R., op. cit., p. 180.
45. In this paper I shall limit myself to an analysis of the influence of the corporate classes and upper middle classes on the federal executive and legislative branches.
46. There are several references showing the concentration of corporate wealth in this country. See the chapter Monopoly Power: Increasing or Decreasing? in Hunt, E. K. and Sherman, H. J., op. cit., pp. 267-82, and also Committee on Government Operations of the United States Senate: *Disclosure of Corporate Ownership.* Washington, D.C., Govt. Print. Off., 1973.
47. Hunt, E. K. and Sherman, H. J., op. cit., p. 270.
48. According to the Pattman report, the 100 largest banks (of a total of 13,775 commercial banks) hold 45% of all deposits. Pattman Committee Staff Report for the Domestic Finance Subcommittee of the House Committee on Banking and Currency: *Commercial Banks and Their Trust Activities; Emerging Influence on the American Economy.* Washington, D.C., Govt. Print. Off., 1968.
49. Committee on Government Operations of the United States Senate, op. cit.
50. Mintz, M.: Eight institutions control most of top firms. *Washington Post,* January 6, 1974, pp. A1 and A16.
51. Mintz, M., ibid., p. A16.
52. Iglehart, J. K.: National insurance plan tops ways and means agenda. *Nat. J. 6:* 387, 1974.
53. Bodenheimer, T., Cummings, S., and Harding, E.: Capitalizing on illness:

The health insurance industry. *Int. J. Health Serv.* In press.
54. Ibid.
55. Mintz, M., op. cit., p. A16.
56. Iglehart, J. K., loc. cit.
57. Health plan progress. Editorial. *New York Times,* April 7, 1974, p. E16.
58. Kelman, S.: Toward the political economy of medical care. *Inquiry 8:*30-38, 1971.
59. MacIver, R. M.: *Academic Freedom in Our Time.* New York, Gordian Press, 1967, p. 78. Cited in Miliband, R., op. cit., p. 251.
60. Beck, H. P.: *Men Who Control Our Universities.* London, King's Crown Press, 1947, p. 51.
61. Flexner, A.: *Universities: American, English, German.* New York, Oxford University Press, 1930, p. 180.
62. Galbraith, J. K.: *The New Industrial State.* Boston, Houghton, Mifflin, 1967, p. 370.
63. Pusey, N. M.: *Age of the Scholar: Observations on Education in a Troubled Decade.* Cambridge, Harvard University Press, 1963, p. 171.
64. For an updated reference analyzing the backgrounds, roles, and educational attitudes of university trustees see Hartnett, R. T.: College and University Trustees: Their Backgrounds, Roles and Educational Attitudes: In: Skolnick, J., and Currie, E.: *Crisis in American Institutions.* Boston, Little, Brown, 1973, pp. 359-72.
65. See Servan-Schreiber, J. L.: *The Power to Inform: Media—The Business of Information.* New York, McGraw-Hill, 1974.
66. Miliband, R., op. cit., p. 238.
67. Marcuse, H.: *Repressive Tolerance.* Boston, Beacon, 1972.
68. Van Gelder, P., leader of the Baltimore American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). Personal communication.
69. Freidson, E.: *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York, Dodd, Mead, 1970, p. 72.
70. Frankenberg, R.: Functionalism and after? Theory and developments in social science applied to the health field. *Int. J. Health Serv.* In press.
71. For further elaboration of this point see Berliner, H.: *A Larger Perspective of the Flexner Report.* Baltimore, Johns Hopkins University. In process.
72. Navarro, V.: A critique of the present and proposed strategies for redistributing resources in the health sector and a discussion of alternatives. *Med. Care 12:*721-42.
73. While still keeping in mind Miliband's definition of the state, I shall focus, as stated before, just on the executive and legislative branches of government.
74. Green, M. J., Fallows, J. M., and Zwick, D. R.: *Who Runs Congress?* Ralph Nader Congress Project. New York, Bantam, 1972.
75. Marx, K. and Engels, F.: *The Communist Manifesto.* New York, International, 1960.
76. Quoted in Hunt, E. K. and Sherman, H. J., op. cit., p. 284.
77. Miliband, R., op. cit., pp. 56-57.
78. Hunt, E. K. and Sherman, H. J., op. cit., p. 288.
79. Therborn, G.: Power in the kingdom of Sweden. *Int. Soc. J. 2:59,* 1965.
80. Common Cause: *1972 Federal Campaign Finances. Business, Agriculture, Dairy and Health.* Washington, D.C., Common Cause, 1974, vol. 1.
81. Matthews, D. R.: *The Social Background of Political Decision Makers.* New York, Doubleday, 1954, pp. 23-24. Quoted in Miliband, R., op. cit., p. 61.
82. Schattschneider, E. E.: *The Semi-Sovereign People: A Realistic View of Democracy in America.* New York, Holt, Rinehart and Winston, 1960, p. 31.
83. Titmuss, R.: *Income Distribution and Social Change.* London, Allen and Unwin, 1963.
84. Kolko, G.: *Wealth and Power in America.* New York, Praeger, 1968.
85. Bodenheimer, T.: Health care in the United States: Who pays? *Int. J. Health Serv. 3:*427-34, 1973.
86. Rimlinger, G. V.: *Welfare Policy and Industrialization in Europe, America and Russia.* New York, Wiley, 1971.

87. Sigerist, H. E.: *Landmarks in the History of Hygiene.* New York, Oxford University Press, 1956. Quoted in Terris, M.: Crisis and change in America's health system. *Amer. J. Public Health 63:*317, 1973.
88. Piven, F. F. and Cloward, R. A.: *Regulating the Poor: The Functions of Public Welfare.* New York, Vintage, 1971.
89. Ibid. Cited on p. 268.
90. Committee on Government Operations, U.S. Senate: *Confidence and Concern: Citizens View American Government: A Survey of Public Attitudes.* Part I. Washington, D.C., Govt. Print. Off., 1973, p. VI.
91. Woodson, D. W.: National health insurance: A big role reversal takes place in Congress. *Med. World News 15:*69, 1974.
92. Bodenheimer, T., loc. cit.
93. Fein, R.: The new national health spending policy. *New Eng. J. Med. 290:*137-40, 1974.
94. Quoted in O'Connor, J., op. cit., pp. 55-56.
95. Glasser, M. Director of the Social Security Department of the United Automobile Workers of America (UAW). Personal Communication. Also Glasser, M.: The Pros and Cons of the Private Insurance Involvement in the Health Sector. Presented at *Policy and Planning Seminar,* School of Hygiene and Public Health. Baltimore. Johns Hopkins University, April 18, 1974.
96. O'Connor, J., op. cit., p. 142.
97. Roemer, M. I. and Mera, J. A.: "Patient-dumping" and other voluntary agency contributions to public agency problems. *Med. Care. 11:*30-39, 1973.
98. Navarro, V., loc. cit.
99. Miliband, R., op. cit., pp. 164-65.